DOCUMENT RESUME

ED 135 123 EC 092 857

AUTHOR Schacht, Leatrice S.; And Others
TITLE Personality Development and Learning Disabilities: Long Term Follow-Up of Pschotherapeutic Remediatien.
PUB DATE Aug 76
NOTE 49p.; Paper presented at the International Scientific Conference of IFLD (3rd, Montreal, Canada, August 9-13, 1976)

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS Case Studies; *Educational Methods; Elementary Secondary Education; Emotional Problems; *Learning Disabilities; Longitudinal Studies; *Psychotherapy; *Remedial Instruction

ABSTRACT

The authors describe their clinical experiences in working with learning disabled children who have emotional disorders as well. Their approach, "psychotherapeutic remediation," is explained tc combine psychodynamic psychotherapy methods with special education techniques, and to fuse the tutorial role of a remedial teacher and the therapeutic function of a psychotherapist. Diagnostic and treatment techniques are detailed in two longitudinal case studies of a 10-year-old boy with "neurological deficit and poor reality testing, and a 6-year-old girl with visual perception problems and secondary emotional difficulties. (CL)

**********
* Documents acquired by ERIC include many informal unpublished *
* materials nct available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the micrcfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible fcr the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
**********

ED135123

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

# PERSONALITY DEVELOPMENT AND LEARNING DISABILITIES:

# LONG TERM FOLLOW-UP OF PSYCHOTHERAPEUTIC REMEDIATION

Leatrice S. Schacht, M.A.
Walter Kass, Ph.D.
Mervyn Schacht, M.D.

Presented at:
Third International Scientific Congress of the International Federation of Learning Disabilities

Montreal, Canada

August 9, 1976

EC092857

Introduction:

The kind of help children with learning disabilities receive depends upon the treatment concept of the helping professional. Methods of deficit screening and differential diagnosis are now in common use among teachers, psychologists, and guidance personnel in the educational system. These procedures are also well known among medical, psychiatric, psychological, and tutorial specialists from whom the child seeks help. However, there is as much diversity among professionals in the diagnosis as in the remediation of the variety of learning problems these children present.

A child without adequate language communication will be handicapped from the beginning in the major aspects of personality development such as: the development of primary relationships, coping devices, ego functions, and self-image. A child who cannot read, at least as easily as he can talk, will be permanently handicapped in a crucial aspect of receptive communication. His handicap forecloses his independent access to our common heritage of the recorded past, limits his perspective of the future, and results in serious life-space constriction, especially when the child already has a poor sense of sequence in time and space, and orientation to the future.

When parents and teachers discover a learning disability, they are seldom aware of the intense anguish with which the child views his own shortcomings and wonders why he is so

different. As Edith Klasen (1) reminds us, "only a few are so extraordinarily talented that they are able to automatically compensate for their difficulty," as "peers, teachers, and parents criticize, ridicule, and press for better performance."

We have previously summarized the problems of specific learning disabilities and their consequent impediments to progress in school as follows:

> The learning problems reach a critical point in the third and fourth grades, when tool skills must then be applied at the level of concepts and abstract ideas. Primitive perceptual modes persist. The child has not yet developed a basic hierarchy of classifications and conceptual organization. He therefore has difficulty dealing with number concepts when arithmetic moves beyond concrete operations. He struggled to comprehend complex language. Unable to cope with symbolic relations of people and events in time and space, he cannot master the materials of geography, history, and social studies. His inability to grasp subtle aspects of human purpose and motives also affects his classroom membership. As his inadequacies become visible to others, his peer group standing suffers, further fostering a self-image of social difference and insufficiency. (2) (3) (4)

So it is that primary deficits often combine with psychogenic stress to produce a disturbed child with both learning problems and deviant behavior. In our experience, deficits characteristically occur in multiples. The child comes for remediation not only handicapped by specific learning disabilities (reading, communication, conceptual thinking, grapho-motor skills, hyperkinesis); he is also multiply handicapped by the ramification of cognitive and integrative deficits into his emotional development and family life. The intervention that best helps such a child will often deal simultaneously with the behavioral manifestations of the psychic aspects and with school skills.

Psychotherapeutic remediation combines the methods of psychodynamic psychotherapy with the techniques of special education and remediation, based on learning theory, knowledge of developmental sequences, and insight related to intrapsychic events. It combines in a single remedial figure the tutorial function of a remedial educator and the therapeutic function of a psychotherapist.

The treatment approach we have called "psychotherapeutic remediation" aims to overcome the sense of alienation deriving from sensory-motor deficits, and from cognitive and conceptual limitations. By facilitating the learning experience, the therapist enables the child to develop a sense of re-entry into the mainstream of human endeavor. Repairing his self-image as a viable learner restores a vital balance between himself and the world. In contrast to tutoring centered on

subject matter and school functioning, remedial psychotherapy is based on a diagnostic understanding of the youngster's growth and development, and is directed toward the total child and all of his functioning in his total life-space. It considers, but does not defer to, curriculum of grades.

Remedial psychotherapy depends mainly on a therapeutic relationship between therapist and child as an unremitting source of motivation toward learning gains. But unlike the teacher, the remedial therapist makes no syllabus demands, imposes no time-table for achievement, assigns no number or letter grades to the child's productions. Rather, the child is valued and comes to value himself only in his own sense of increasing autonomy. In this rationale, regenerated learning becomes not an end, but a means of personal growth. The child's tolerance for frustration and failure increases as he discovers alternative ways of overcoming obstacles to learning within a protective, non-punitive relationship.

In our procedures we do not rely simply on the various published educational materials and training devices now extant. Rather, we use whatever elements of the child's everyday surroundings, whether at home, at school, or present in the therapist's office, that may reveal and define his deficits. We use things he is familiar with and that he can bring to the attention of the therapist, either purposely or accidentally. When indicated, the parents join the treatment with their own regular, continuing visits, receiving, as required, a combination

of dynamic therapy, guidance, and insight regarding the child's impairments. We maintain active liaison with the school so that there is continued feedback among school, parents, child, and therapist.

As in classical psychotherapy, we use the material the child brings to his session as the basic starting point. Rather than build treatment around predetermined training procedures, we employ materials dictated by the particular problem presenting at the time. The child knows from the beginning he can bring in any material that cuases him difficulty: a fight with a peer, trouble with parents, a report to be organized for school. As we talk together about the child's frustrations and sense of inadequacy, we alert him to deficits, help him find compensatory ways of handling them.

One of the first efforts in treatment is to build the child's motivation to tackle the special challenges he experiences. Almost all children show themselves eager to cope once they feel supported. In such a supportive atmosphere a child will rarely use his deficit in a purely resistive way, even though a negation of learning has already occurred in his attempt to shut out a frightening world of failure.

Very early in treatment we help the youngster to realize how his worries, fears, and conflicts may be related to his learning difficulties. A child who suffers from nightmares needs to understand that his strange body sensations, feelings

of instability and dizziness make him more vulnerable to anxiety at night, when it is dark and more difficult to check out his feelings or thoughts. Such children often cannot distinguish between dreaming and waking state, and nightmares are even more terrifying to them than to most children. When both child and family understand this, we may help provide supportive measures. For example, a child who had been sleeping alone on the third floor of his home was moved downstairs and given a special light he could turn on quickly when he awoke. We explored the content of the nightmares from both a physical and dynamic point of view. As he gained insight and mastery, the nightmares diminished.

For the child who has difficulty verbalizing his thoughts spontaneously, a doll house with puppet figures often provides a concrete way of depicting his life situation from both a dynamic and structural point of view. He is able to make the figures describe the simple events of his day, thus organizing his experience of time and space, as well as depicting dramatic events, conflicts over aggression, and other ongoing issues. Many children borrow material from television and books (visual stimuli) as a means of structuring ideas they wish to communicate. Since these children often lack creative fantasy, we utilize such structured productions to interpret their own feelings. Thus, one little girl told the therapist entire sequences from the T.V. program "Bewitched" as a way of expressing strange feelings of sudden change in body state.

The therapist then helped the child find words to relate these T.V. experiences to herself and to identify her theretofore nameless worries.

We see some children who are disturbed to the point of being vulnerable to disorganization. Such children are often unable to distinguish fantasy from reality. Our task is to help them communicate their frightening experiences and fantasies and to help them distinguish the real from the unreal.

The therapist literally helps the child to organize his thinking. For example, one child whose speech was almost completely discontinuous became aware of his thought patterns and able to recognize when as he put it, "Oh, I switched tracks again." We then talked about what caused him to switch, and he began to develop a very important source of ego strength -- anticipatory devices. Often, as the children develop clearer expectations, they begin to experience greater sense of control, which is crucial for reality testing.

In the authors' experience about 75% of the children presenting with a learning problem also experienced a significant emotional problem. The younger the child, the more likely this form of therapy is to be effective. Obviously, it is not the solution in every case, supplemental tutoring or special education may be required. Some children must have the undivided attention of the psychotherapist or cannot expose their deficits.

The following two case illustrations describe two very different problems and techniques of treatment.

Case Example I:

Name: Andy

Age: 10 years, 3 months

Parents: M ther, 42 years - Housewife
Father, 44 years - Professional

Siblings: Male - 16 years
Female - 14 years
Female - 11 years, 4 months

Therapist: Leatrice S. Schacht

Presenting Problem: Andy was referred by a psychologist neighbor who had been concerned with what she considered Andy's deviant behavior since early childhood. Attempts to obtain an evaluation in second and third grades, were not consummated. In fourth grade the parents became increasingly concerned with Andy's poor school work and difficult behavior at home and were again seeking help.

Developmental History: (At time of presentation in 4th grade) Andy is the youngest of five children, four now living. The eldest, a boy, died in early infancy. At age 3 months, Andy was hospitalized for 8 - 10 days with most of that time spent in a croup tent. An examination of the hospital records does not show undue respiratory distress. Pre-natal and birth history were unremarkable.

At age 6 months, Andy became a violent head banger - a condition which lasted until he was two and one-half years of age. He ate well, was an extremely active child, into everything, responsive and seemingly outgoing. Developmental milestones were reached at appropriate ages. His play activity,

however, did not follow usual developmental patterns but was always quite disorganized and scattered. He showed an early definitive left-handedness. He was somewhat awkward in learning to care for himself, tying shoelaces, etc., and would let others do for him.

At age 3 1/2 he was given glasses. The opthalmologist feared his condition would worsen, but actually it has not and with correction, his vision is completely adequate.

As a small child he liked to dress up in girl's clothes and expressed his feelings that girls were lucky that they could wear pretty things. He has always been a "mother's boy".

The parents realized that he was immature, did not send him to nursery school but had him participate in a local neighborhood group and then held him out of kindergarten for one year because of his December birthday.

When Andy started in school the parents first felt alarmed concern for him. Andy thought that other children were laughing at him and he pushed them around. He was over eager in his attempt to be friendly and at times almost inappropriate. He began to watch more and more T.V., and developed rituals and phobias in connection with sleeping.

In first grade he showed poor reading readiness, read a page from right to left, reversed letters and numbers (reading 12 as 21). This persisted. On testing in second grade, the

school psychologist found a "visual perceptual problem." His I.Q. on the WISC was 91. The psychologist suggested psychological assistance for Andy's fear and uncertainty.

In third grade the pediatrician prescribed Ritalin, which seemed to help a little, although the learning problem persisted. In his own fashion, however, Andy learned to read. His third grade teacher apparently gave him more individualized attention and he appeared to gain with this. Now in fourth grade, however, his disorganization and poor achievement were more apparent than ever. He was having great difficulty learning script, spent large amounts of time daydreaming and was increasingly upset, irritable and uncontrollable at home. He used foul language, was seen masturbating, did not seem to recognize what was appropriate behavior. Yet there were many things about him which were engaging, kind and involved.

Family History: Careful scrutiny of the parents' background gives no indication of problems of sufficient severity to account for Andy's condition on the basis of parental deviations. Though it has been hard for them to recognize the extent of Andy's deviation, they are both earnestly involved parents. Father's developmental history is unremarkable. He is a highly intelligent, successful professional who devotes substantial time to community activities. Mother has emerged as a rather self-contained, restrained woman who devotes herself energetically to husband, children and community. It is

important for her to feel that she can tolerate the strains of life. The parents have a close, supportive marital relationship. There is no family history of learning difficulties. Siblings have developed adequately socially and educationally.

Summary of Our Psychological Tests: At present testing Andy achieves a score on the WISC of 103 (Verbal scale 99; Performance scale 107). His scores show great variability, with the lowest score on a test involving comprehension and judgment. His Bender showed developmental immaturity and on the 5-second recall, poor conceptualization of the designs. Handwriting is poor and deteriorates rapidly as the complexity of the assignment increases. Throughout the tests he shows extreme fatigability with increasing difficulty in performing when the tasks become more complex or when he becomes tired. For example, if he has only to write or remember, he may be able to do one, but if he has to do both at once he cannot function in an integrated manner, and response to both tasks suffer. Figure drawings show great distortion of body image. Word Associations are bizarre, and recall of responses reflects poor memory functioning. On Story Recall, the immediate memory is poor but improves with repetition and reinforcement. The Sorting Test shows markedly concrete thinking in forming concepts. Reading tests show fairly adequate skills but a lag in capacity to comprehend. He can read fourth grade material adequately but comprehension is on the second or

third grade level. The Rorschach clearly delineates confabulatory deviant thinking consistent with poor reality testing and a thought disorder. The stories to the TAT show discontinuities of thinking, poor orientation in time and space, lack of understanding of the concepts more or less. He uses peculiar logic. Fantasy and reality lose their sharpness of distinction and are allowed to co-exist and vacillate. He loses distance from the cards and becomes caught up in his own fantasy. At times he seems almost unable to distinguish between sleeping, waking - life and death. He goes to great lengths to put strong, aggressive impulses at a distance. He clearly demonstrates a severe problem in sexual identification. In brief, the tests reveal a convergence of organic and psychological abnormalities. Andy is a child with a poor sense of self, sexually, motorically, and in the world of reality. The following two TAT stories are illustrative:

(12F) There's an old wicked man behind that <u>other</u> man (figures usually seen as women), he's - that - man (muttered) .. that other man with the lipstick . . . Yea . . . looks a - he has sort of girl's lips - um, he's thinking of what to do, and that other man's thinking of something - the ending is that the old man's thinking of trying to do something to him - probably gonna try and kill him. . (Why would he want to do that?) I haven't the faint - probably he doesn't want - all the girls are - everyone like that - after him; he just wants to have lots of girl friends . . . and everything. (What happened?)

I don't know what happens - well . . . he just goes home, that young man and then the other - that other old wicked man is following him in the dark, in a dark alley - just is and - follows him home and then later at night he sneaks in - when he's in bed - and stabs him . . and . . . . . then he lives happy dead after. (?) It would be - he lives happy dead after. (?) Happily dead after.

(12M) That old man found that he is dead . . . (?) that old man found that he was dead on his sofa . . . . and . . . . and then, and then he's thinking of that, that other man's really asleep, that old man's thinking he isn't really dead. . . .so the ending is . . . Umm, that old man, the little man thinks he's dead, what happens is, well, eh, what happens, he . . . . I forgot what happens. I forgot. Well, what happens. . uh . . . . then he sleeps . . . . he thinks he's dead but he's really asleep. (What finally does happen?) Sooo, he's dead - he's dead. Well, someone must have stabbed him. Well, and then he's just dead. How many of these have we done, 4 or 5? Umm let me see. He's just dead that's all. (Feelings?) He has none - that other man has the feeling - that's a stranger and his feeling is - well - that he'd get in there and in the house and how did he get in without making any noise and how did he get in when he shut the door. (Whose house?) That old man's. It's all sort of scary, felt sort of scared - that old man. He snuck in when that old man was out shopping and then he

just fell asleep - had a few goodies and went to bed - must have overate and then this man came along and just shot him. (Who?) The man -- well, it's just an imaginary thing - but the man shot a bullet up in the air and then it came through this glass and then it shot the man and --- then -- (What's imaginary?) Well, this isn't true - not in the -- there's this target practice on the other side of the world - it's like in Japan and then they shoot a bullet and then it goes all the way acorss - to merica and right through his window and into him - its poisonous - so he's dead - and - and he's dead by accident. When, when this man comes (yawn) this ah man who wanted to -- comes over and says like "hey" and like nothing answers and then "hey" and nothing answers.

Initial Clinical Interviews with Andy

A tall, feckle-faced, boy, Andy spoke with great discontinuity, jumping from one idea to another, associating as one would expect in primary process thinking. He drew pictures demonstrating great anxiety regarding bodily integrity, related frightening dreams and experiences of dizziness and anxiety. He showed numerous tics, with eyeblinking especially notable. His scattered, disorganized speech, however, gradually diminished as communication was established. He described many experiences of feeling unreal, particularly in dreams of fainting, slipping, falling, etc. When watching television for a long time he seemed to see a blinking after

image and felt dizzy. He was extremely passive, collapsing into a chair as if he had no bones or muscles. Yet with great verbal ability he established a firm relationship and slowly made himself clearly understood. The concreteness of thinking was often demonstrated in the unusually literal way he understood so many things around him. He was uninterested in the usual boys' games (baseball, etc.) and was himself aware of his poor motor coordination as though very frustrated with himself. He tended to mimic expressions of other people, particularly the feminine members of his household.

Diagnostic Conference and Recommendations:

1. Neurological deficit characterized by learning difficulties, especially with numbers, poor coordination, memory difficulties, distorted perceptions and experiences of physical instability (dizziness, etc.).
2. Emotional disorder demonstrated by autistic fantasy, confabulation, bizarre associations, and poor reality testing.

We recommended a consultation with a pediatric neurologist, who noted "this youngster shows unequivocal evidence of organic dysfunction of the central nervous system, a learning disability, a perceptual problem with visuo-spatial difficulties, spasticity with deficient motor function, and a cerebellar deficit. The relative macrocephaly apparently has been present since early infancy and at the present time is of uncertain significance.

The E.E.G. record is poorly organized and slower than normal. It shows, in addition, scattered sharp forms in the resting state and definitely enhanced by hyperventilation.

This is an abnormality somewhat suggestive of a paroxysmal disorder. Skull x-rays showed no abnormalities."

Therapy:

The techniques of therapy with this youngster made use of traditional subject matter and materials for therapeutic and educational purposes, in an effort to sort out Andy's feelings and conflicts and to gain an understanding of how environmental stimuli confuse him. When he first came he had very little orientation for time, and I would write a card for each appointment that he could keep for himself to feel some sense of control. Even with the card, he would rehearse the time of his next appointment before he left. After six months, when the appointments took on a pattern of their own, he proudly told me that he could remember without the cards.

Andy made a great deal of use of the doll house to concretely depict his life situation from a dynamic and structural point of view. In the beginning he was extremely concrete and simple, taking the various figures and describing time sequences -- when it was time for father to come home, when it was time to get up, when it was time for dinner. He would act out and verbalize the organization of his life space and depict the pattern of his day, traumatic events, and conflicts over aggression.

When he was upset, the structure of his play would show disorganization, which was a clue in identifying what was upsetting him. For example, when he changed schools the adjustment was very difficult, and he began to show the parental figures of the doll house (as he had depicted them very early)

acting in a hostile, aggressive manner. He would express counter aggression by making them fall out windows, etc. In exploring what was making him angry, we found that he saw adults in the school (like his parents earlier) as not understanding his needs. Actually, his teacher at that time raised his voice a great deal, often for dramatic emphasis rather than for scolding the children. Nevertheless, this frightened Andy and recapitulated his earlier experience with his parents of being unable to communicate. Finally, over a period of many sessions, we were able to understand his feelings and problems and began to cope with them by changing the structure of his life situation and putting him in a different class.

Drawings, too, allowed Andy to depict and verbalize, both graphically and concretely, the organization of his life space. In addition, they helped reveal his lapses in understanding and gave us a chance to discuss various questions, especially body structure and function. His drawing of a dream in which there were ponies going up a hill, with a pony provided for each child but him, helped us to see the struggle he experienced and his feeling that he lacked the support that other children had. A drawing pertaining to fractions indicated his lack of adequate conceptualization and gave us an opportunity to discuss this directly as a learning problem. Another drawing in which he tried to portray a woman's breast brought out thoroughly confused notions about sexual functions and gave him a chance to express his curiosity about female anatomy.

At the beginning of treatment, Andy was very free in discussing many thoughts and feelings but expressed them in a highly disjointed manner, so that we spent much of the first phase of treatment engaging in an analysis of the way in which he communicated his thoughts. He became able to observe himself "switching from one track to another", at first cuing me in when he made a switch and later cuing himself in, so that finally there was an automatic reorganization of his communications. It was interesting that Andy's family had become very much accommodated to his strange way of talking, and only after many months of treatment did his mother suprisingly say, "I think I've had my first normal conversation with Andy; I never realized how different his conversation was from others."

Andy was an unusually verbal child, which was helpful in treatment. In the early months he talked a great deal about compulsions and moods, defining himself as having three moods -- plain, excited, and blinking. The plain mood, as he said, was just ordinary; the excited one was happy; and the blinking one referred to feeling out of sorts and nervous.

As treatment proceeded, a great deal of tension and discussion centered around his concrete thinking, which often led to strange misunderstandings. For example, he would not wear black pants because he remembered hearing that black absorbs heat and was afraid that he would be burned. While I acknowledged his fear and anxiety about himself, I also

gave him facts to clarify these misunderstandings. At another time, when we were talking about a feeling that he had had, I asked him to tell me something that would be an example of it; he responded by giving me an arithmetic example. We then discussed how he might avoid those words which would lead him astray or clutter up the more meaningful content of his communication. He developed a game, based on his insights, in which he would try to fool me by responding in a concrete and confused manner, though quite aware of what he was doing. At other times he became genuinely perplexed by his misperceptions, to the point of frustration and anger. I had to learn to cue myself in so that I could prepare and structure the way for him. He became able to make relevant associations in discussion of feelings as well as dreams. It was surprising to me, considering his associative defects, to find him able to bring meaningful material to relate to our exploration of thoughts and feelings.

From the beginning Andy flooded our sessions with accounts of one dream after another, each manifesting strong bodily sensations (probably related to the seizure potential) with great anxiety. We handled them by my giving him some understanding of his body's behavior and discussing how frightening his peculiar sensations were, especially at night when he could not "check them out." Little by little, we began to pay some attention to analysis of the actual content of the dreams, as they took on more obvious meaning in relationship

to our discussions of his feelings and his relationship to me. We began to use the dreams for insight. We discussed one dream in which he was on N rthwest Airlines. The plan was sliding and shaking, and there was a lady controlling it. He had to go in the luggage department in the last class, which was called "A". Finally, he jumped out into the air and abandoned the plane, landing safely in his own back yard. This was one of the first dreams in which the terrifying body experience did not become overwhelming, and defenses appeared. He associated the cntrolling lady with his mother and grandmother, who had been very protective of him but who structured things for him a great deal and were "bossy". He associated the classes with socio-economic classes and went on to say that he felt he was not in the last but perhaps in the first class. Continuing with the associations, he brought up the question of intelligence and his feeling of being last. Finally, he said that if he had the choice of being rich or smart he would rather be smart.

From this same dream ensued a great deal of discussion about the word "retard" that children often level at others who appear different. We were able to discuss in realistic terms the nature of his disabilities and the fact that although some of the ways in which he thought made him appear slow, he actually was not retarded and could develop techniques to overcome some of his difficulties. Our discussion of some of the ways in which he had already done so proved reassuring.

For example, he had learned that when he was talking he often drew a blank and would say, "I forgot", becoming quite anxious and annoyed with himself. Little by little I was able to show him that the memory was still in his head; it was only a matter of getting back to it. Sometimes he could remember something simply by taking a couple of minutes, relaxing, and waiting till the thought came; other times we would trace back together on the associative path to find it, and he would be delighted when he could come upon his memory.

As time went on, Andy occasionally had happy dreams, which were a source of enormous gratification to him. They were the kind of dreams that small children often have -- in one, he found himself in candyland; in another, he owned a restaurant in which he was a waiter at first but then was asked to sit down with the others and was served the chef's best meal, the specialty of the house, a peanut butter and jelly sandwich. Andy and I both took great pleasure in these dreams. Pleasurable aspects of body sensation began to appear more, and he even had a dream in which he experienced the delight of flying. Dreams of frightening movement, earthquakes, and dizziness, interspersed with the happy ones, became less and less frequent.

One dream sequence which took place over a long period of time had to do with his relationship with me and was set off by our discussion of the difference between apples. (I am

continually aware of pointing out similarities and differences to him) He had brought in a McIntosh apple and I had a Delicious apple in the little refrigerator that I keep in my office. After a discussion on the subject, he ate my apple and left his apple with a sign on it saying, "This belongs to Andy." I promised to keep it for him. In the mean time, he had a series of dreams which revolved around the question of whether he could trust me or whether one of my other youngsters might eat it. Finally, after many weeks went by and we had worked through the meaning of his symbolic act, he took the apple and ate it.

Whenever possible I tried to get Andy interested, at home and during our sessions, in any kind of game that would help him with his learning difficulties and at the same time be fun. He had never played games with his peers, as children of his age usually do, so that learning to play a few games meant the possibility of developing social skills. In addition, being able to win was a great boost to his self-esteem. His first feeling was that he couldn't tackle a game, but as soon as he saw that he could, he developed an interest and asked to play various card games, checkers, etc. with members of his family and friends.

One of our early games involved the use of an adding machine which I had in the office. This was an early method of helping him to organize: he would plan a party of go-

shopping, figuring out how much he needed of various items, what the cost might be, and adding it all up on the machine. At that time he did not know place values and this game helped him learn them.

As many children do in treatment, Andy often asked questions about the therapist. Mostly he asked the kinds of questions in which he sought validation of his own experiences as well as showing a genuine curiosity. To me the word "know" is always a cue word, since one of my major interests with such children is to get them to enlarge their horizons. Occasionally I handled such questions by exploring his feelings about them, but to some extent I was also willing to discuss my own reactions. At times we had talks about his vacations and my vacations, which turned out to be valuable as geography lessons. Often we spent a lot of time exploring some area of information that was not clear to him, possibly pertaining to different kinds of materials and their properties or kinds of foods and what they are made of. Our discussions were a source of learning and satisfaction to him and encouraged him to ask more questions, not only of me but of others. As a therapist I worked to provide him with models and structure for dealing with the external world.

With children such as Andy, it is important to help the parents understand the way in which their child functions, so that they can apply various remedial tehcniques to the everyday life of the child. Through regular interviews, I gave Andy's parents support in handling their youngster. They

learned to appreciate questions from him. By learning to sense his moods, to anticipate his loss of control, and to help him structure his world, they were able to manipulate his environment to an extent. They provided him with a bulletin board for reminders and a calendar on which he and his parents could note daily happenings. They set goals and limits but remained tolerant of his actions. Instead of putting up with any kind of behavior on his part, they expected him to function in areas where he could succeed, and his ability to do so was a boost to his self-esteem. Even with all his gains, however, Andy remained an extremely difficult child.

Andy and I met three times weekly, spending a good part of ourtime dealing with his learning at school in an effort to keep him in a regular classroom situation. He spontaneously brought in school materials that gave him trouble. He learned to catch his reversals and to shift from one kind of computation to another in arithmetic. We would organize simple reports for him, most often by his telling me the story and then either writing it or dictating it to me. He learned to think and plan more, rather than jump impulsively into something. Despite Andy's gains, his parents wanted him to have the advantage of a special school.

After this transfer, I saw Andy on a regular but less frequent basis. Life at the school was often difficult. Exposure to a new teacher or new tasks were upsetting and

frightening to him, and his defense was often passive resistance. His behavior elicited pressure from his school and family, who saw it as defiant. He did work especially well with one teacher, but when he changed to a less patient teacher two years later, he went through several months of regression.

After three years in the special school, Andy was operating above grade level in reading and was barely at grade level in math skills; he was also doing well in spelling. His capacity to organize and deal with complex matters, though still limited, was much improved. Although he was in much better condition psychologically and was no longer actively disorganized, the family continued to have great difficulty in managing and disciplining him. We decided that it might be useful to place him in a residential school. At that time, 3 1/2 years after he had initially come to us, a re-evaluation was done to assist in further school planning.

Results of Second Testing (by Walter Kass, Ph.D.):

"...gain in social comprehension and concepts. Information level has not advanced and vocabulary level has not kept pace with the years. Perceptual and motor-expressive skills remain relatively static... mild improvement in immediate and delayed recall of auditory language input. Writing... greatly improved... less rigid and more versatile intellectually and emotionally... more relevant, socially centered thinking... less morbid, more socially appropriate and diversified... Thematic material not bizarre -- human relations described

relatively normal. Still themes of dizziness, falling and fainting. . . Requires continued special education in which deficit areas will not be taxed and where he can have a satisfying peer group experience. Major problems that will be crucial for psychotherapy are impulse control and sex role identity."

Before he left for boarding school, Andy experienced great anxiety about leaving home. He had been somewhat prepared for the change by making short visits by airplane to relatives in different cities. Since his school was not at a great distance, we arranged to meet during vacations for continuing support. We had hoped that the new school would provide some group and individual treatment, but this turned out to be very limited.

The initial year was a difficult one for Andy, but he nevertheless made good progress in both his educational and social adjustment. He began to participate in physical activities and improved his overall ability in athletics, developing very rudimentary skills in bowling, swimming, tennis, and ice-skating. The school noted improved male role identity, although the underlying identification problems still remained. By that time, almost 15 and over six feet tall, with a deep voice and large features, Andy had a much more masculine appearance and saw himself functioning as a man. His largely passive behavior took on more self-actualizing patterns. Much to his and his parents surprise, he received

at the end of the first year the award for making the most progress of the students in his age grouping.

After two years Andy wished to make a transition to a "more normal" school environment, although recognizing that he still needed considerable protection and structure. After his requesting a change for a long time, his parents finally felt that he was ready for a shift, and they began to make investigations for new placement.

In our infrequent sessions at that time, Andy showed much more insight, often reviewing former behavior and fears with current understanding. He no longer experienced the same frightening dreams of the past nor did he have experiences of instability. It is of interest that he still showed a mild shoulder tic, presumably neurogenic. He was clearly aware of his past difficulties and fairly realistic about the problems of adjustment he would have to face in making yet another move. For the first time, he was able to have open discussion with his father and to feel more acceptable to him. The family noted that when he was home he became more and more of a functioning family member. His former temper tantrums and impulsive behavior had all given way to an attempt at control and a capacity to respond to the needs of others.

Two years ago Andy returned to a modified program in the regular school, repeating the tenth grade. He was then functioning close to grade level, except in math. We resumed regular weekly therapeutic sessions. Academically, he has functioned fairly well, passing all his subjects. With the exception of Social Studies and one English course, all of his courses were modified.

Unfortunately, Andy was unable to establish peer contacts and remained quite isolated, which contributed to regressive, angry behavior at home. His outward attractiveness and social conformity made it hard for his family to understand his difficult behavior at home. Normal attempts at adolescent independence caused further conflict, especially since his behavior was usually so passive. His most positive achievement was learning to drive. He took the written test three times but passed the driver test immediately. Still, he drove very cautiously and would not venture far. His life was constricted.

As he enters his last year of high school, Andy has cut our visits to two times per month. His school recommends vocational training; he talks of going to college under a special program. He has voiced interest in working with the airlines or in becoming a cook.

I feel that Andy has moved beyond my early expectations, and I am anxious to motivate him further in taking a more active role and in finding adequate social contacts. His task has changed from developing organization and insight to dealing with the implications of creating a satisfying adult life.

Case Example II

Name: Betsy

Age: 6 years, 8 months

Parents: Father - businessman, M.S. in Business

Mother - housewife, attended college, but did not graduate.

Sibling: Female - 4th grade; 10 years

Therapist: Leatrice S. Schacht

Presenting Problem:

One year ago the family sought help for their younger of two girls, Betsy. She was beset with emotional and school-learning difficulties which the parents insightfully recognized and were concerned with for some time. She herself recognized them. When anticipating her kindergarten year, at age five, she said to mother, "Don't expect me to be as smart as Sister in school." At first, the school was reassuring but then they, too, realized that there was a problem and an evaluation was needed. She was also, at that time, especially difficult after a recent hospitalization and a tendency to temper tantrums showed a sharp increase. Now, after a year of intensive therapeutic remediation, on a three-times-weekly basis and repeat of kindergarten in a private school, re-evaluation was done to assess her development and to provide a framwork for continued remediation with me and within her new special school setting.

Procedures:

Last year Dr. Schacht obtained basic medical and developmental histories and the parents' view of the problem. Dr. Kass and I did the diagnostic testing, which consisted of the WISC, Stanford Binet, Rorschach, CAT, Word Association, Bender Gestalt, Figure Drawings and various informal tests of laterality, memory, hearing and learning skills. The test procedures done this year were essentially the same.

Background Information:

Last year's clinical assessment noted that she had "difficulty in identifiable cognitive areas. She could count a series of numbers up to ten but could not learn to remember the number eight visually. She could only count as she touched. She could not learn to recognize letters of the alphabet or recite them. She had difficulty in putting words together. She had very poor memory. In nursery school at three, she could not remember the name of any teacher, even when repeated many times and over a long extended period of time. From September to April, she never mentioned the name of a single child in after-school conversation with mother. She played very well with children as long as no learning was involved. Her speech was indistinct, with poor articulation." As will be noted in the current report, there has been very considerable change in all these areas of cognitive development.

Mother was physically and psychologically ill during the pregnancy and weighed less than 100 lbs. at term. She was born at term with only two hours of labor and without difficulty. However, at the end of the first year she weighed only fourteen pounds, was fretful and slept poorly. She had serious digestive-absorptive difficulties diagnosed as allergy. She walked and talked at 14 to 15 months, which the parents considered slow compared with her sister. She said words at 18 months but even at 2 years speech was often not understandable and displayed a babyish pattern of speech and intonation. She was slower than her sister to be toilet trained - after three years for daytime and after four years for night. She showed strikingly babyish mannerisms and marked fearfulness of people and things until treatment started. She feared the dark, going to the bathroom at night, the unexpected sound of bacon frying, and animals, and would become frenzied in response to such experiences. At that time she related fearfully to people, would cling and hide behind her mother, withdraw and remain silent. She was temperamental and unpredictable.

She has a left congenital cataract with diminished vision in the left eye but gives no sign of being handicapped by this. She had chicken pox at age three months and a succession of ear infections for the first year of nursery school. Last year, she developed an infection of the left foot and had to be in the hospital for ten days, spending three weeks at home thereafter.

There are no examples of learning difficulty in near or far relatives known to the family.

Summary of First Testing:

On the WISC, Betsy achieved a score of 86 to 91, Performance of 114, and Full Scale of 101 to 108. The total score was misleading because of the fact that she demonstrated evidence of a specific language disability which accounted for the lowering of the Verbal scores. She showed dysphasic elements, could not get the words to name things that she actually recognized. Asked to identify the thumb, she first said, "pinky." When pressed and made comfortable so that she could try again, she came up with the correct response. She had difficulty at times comprehending spoken language, showed auditory imperception and misheard many words. She could not spontaneously ask for the cues that would help her to understand. However, when provided cues she showed a good capacity to respond and use them. Poor language and number concepts made for rigidity and inability to shift. She had difficulty in sequencing, could repeat numbers forward, was unable to reverse and repeat them backwards. At that time, if she touched the object as she counted, she could reach to eight or nine but could not count more abstractly. Asked how many legs a dog has, she said, "two" but when pursued, it was clear that she really understood that such an animal had two legs on each side but did not readily abstract that into the

total concept of four. She reversed sequence in looking at things and on Picture Arrangement went from right to left rather than the usual left to right. Despite good motoric skills, there were many instances where there was confusion with mixed dominance. She could identify left and right hands but was not consistent in her use of right or left. She hopped on her right, combed with her left, wrote with her right, threw with her right, picked up with her left. She sighted with the left eye for both near and far viewing. However, her motor skills were fairly well developed in comparison with language skills and her visual perception was generally quite good. She could quickly pick out what was missing from something, how things were alike and different.

On the Stanford-Binet, her score was consistent with the WISC - 87 - again doing better with grapho-motor skills. At that time she had difficulty on the Binet in understanding differences and similarities. When asked to draw geometric figures, she handled the circle and square nicely but could not draw the cross. She drew two lines, one above the other, but both in a horizontal plane, not being able to get the concept of crossing one over the other. But when given a model of a cross to copy, she recognized it and was quickly able to reproduce it. On the Bender, her perception was good, but motor control slightly below age in this type of

task, with directionality and sequence giving her difficulty in handling this. Drawings were slightly below age level, evidencing body concern. On the Rorschach there was great difficulty in integrative skills. She could only point out isolated percepts in a way characteristic of a retarded youngster, not having the concepts with which to integrate. On the CAT, she could not make up a simple story, again showing integrative difficulty. She did not get subtle relationships but only concrete functional ones.

There was considerable cognitive variability throughout the testing. At times her vocabulary was quite good, at other times there appeared to be a memory gap for simple things that one would expect a child like this to know. There was little concept of time and space relationships. She didn't even know the days of the week.

Test findings yielded multiple indications of a central nervous system disorder; affecting language in a variety of ways: absence of spontaneous expression, impaired articulation, auditory imperception, word-finding difficulty (dysphasia), inability to integrate and comprehend relationships, and limited capacity to conceptualize (especially with numbers). She showed herself capable of responding on a higher level when structure was present. Her gross motor development was good, an asset to be utilized in teaching.

We recommended repeating kindergarten in a private school and setting up a program of readiness skills. Her teachers were asked to structure events in sequence, plan and prepare, and help her to express herself. They helped her to learn with color coding and with music and rhythm for motor and kinesthetic reinforcement. Our prognosis was good with proper remedial and therapeutic help. Re-evaluation was set for a year later for further planning.

A neurological consultation was in agreement with our findings and recommendations -- "...neurological deficit... consistent with a static encephalopathy of prenatal origin... possibly...secondary to an undefined viral illness during gestation...significant cerebellar deficit, impaired speech patterns, decrease in auditory memory, impairment of visual perception, prominent learning disability...superimposed secondary emotional problems."

Betsy was so deficient in all basic skills and so helpless to communicate that we felt a year of one-to-one work would "program" essential organization and structure, for future learning. The decision to keep her in private kindergarten for another year was made in hope that a non-academic setting would provide a background on which to emphasize learning of crucial developmental tasks. We recognized that our simple stimuli would elicit rigid and inflexible responses at first, but would provide a framework for more complex responses later.

The approach was radically different from that set out for Andy. Here we first had to help Betsy build language to express her previously unformulated internal experiences before we could deal with them. This child was unspontaneous, looking to others for guidelines and using them if they were sufficiently simple to incorporate for her own growth. She resisted with dignity that which was imposed upon her in an arbitrary, insensitive manner. In earlier times she might have had temper tantrums. With slow and clear speaking on the part of the therapist, Betsy's capacity to imitate soon resulted in spontaneous improvement of articulation without formal instruction.

In early structured sessions, Betsy learned where her things were kept. I encouraged her to choose from several workbooks. For a portion of our work. We worked routinely on basic skills, alphabet, and numbers, for the first 10-15 minutes, on a task of 8's choosing for the next ten minutes. We spent the last part of the session in the playroom if she wished. At first she was perseverative, frigid, and sequence-bound. She could not think of "C" without first going through "A" and "B", "3" without going through "1" and "2". She was eager to deal with "school" concepts of alphabet and number, and little by little she learned. She would go three steps forward and two back, and her therapist went with her. She was not imaginative in my playroom, imitating what she had observed in her kindergarten play group or what she saw of other children.

She looked to others for models that she could follow comfortably. She was able to do a little drawing and after a few months began to produce pictures of psychodynamic significance, for example, a child lying in a hospital bed. Then we were able to formulate a few words to describe her hospital experience. We called her one of "our multiple choice children"; that is, I often had to verbalize several possible ideas for her thoughts and feelings. She would then pick the appropriate one. Within six months she became less upset at home. She began to tell her mother simple stories of a child's being lost or a parent's drowning. I helped Mother use these to make simple interpretations of separation anxiety, and her anxiety diminished.

In about 10 months Betsy began to take initiative in her play group. Her memory improved and she took a small part in a play. She began to report bad dreams and to verbalize fears. At the end of the year she was ready for special school placement. As planned we re-tested her at that time.

Results of Second Testing:

She had made age expected progress in both verbal and motor spheres. Verbal expression was significantly better but still extremely weak. Verbal IQ on the WISC rose from a score of 91 to 106. The alternate scores revealed her variability. For example, when she could not verbalize certain vocabulary items, they were re-administered at another time; then she was able to give good responses. Her concepts varied

from extremely concrete to quite abstract, depending on the day on which the question was asked. The current Binet showed increased growth with IQ at 95. Her Bender and Figure Drawings showed much greater integration, increased maturation, and better body control. She was much less confused in her self image. Perhaps her greatest growth was in the emotional sphere. The Rorschach now showed much greater flexibility and integrative capacity. There were many popular and good movement responses, with good interaction. Where as before the responses were highly perseverated and she failed many cards, she now responded to all the cards. Thus, in the last year there had really been very marked ego and personality development despite all the deficits. On the CAT and TAT she still had difficulty in initiating stories, remaining at the descriptive stage.

Betsy still had a very marked language disability requiring special educational procedures, but was growing in all areas. The articulatory defect and the auditory problem were less. Her concepts were better and on a higher level. Her dysphasia was milder. She still had little capacity for understanding antecedents and consequences. She still needed considerable cues and structure. Her capacity to sequence was better, but she remained sequence-bound and at times got her alphabet letter or her number by starting from the beginning and going through until she reached what she sought. Thus, the program that was set up was still needed, with the

difference that she was now ready for elementary school in a special class, along with continued psychotherapeutic remediation but less frequently. She was more mature with a much richer inner life, good reality perception and descriptive powers, although she could not formulate and express her understanding of events. She was less constricted, less inhibited, less withdrawn. She was more openly expressive and object-related with a good range of perception, but still perceived much more than she can communicate.

Remedial Work at the Time of Starting School:

Betsy was just finishing the first reader of the Merrill Linguistic Readers. Despite her strong visual abilities, it was decided not to use those primarily but to work through her weakness (since she was so highly motivated) in order to develop good phonic skills and good basic concepts. At the same time, however, she was beginning to develop some sight vocabulary. It was important to go very slowly with her in a sequential manner with constant repetition. In our sessions, she showed herself anxious to work in that way by choosing from a wide variety of workbooks and reading books and moving back and forth from easier to more complex things, depending upon her readiness. The Book Lab materials were used and she was on the Second Reading Helper, had learned to read the colors, and was as would be expected, very good in understanding similarities and differences. From the Book Lab series she had also worked with My Own Writing Book and

My Own Reading Book, part of the intersensory reading program. However, she found this more difficult and would pick it up only at times. She used two simple math books in which we were working on concepts from one to ten. The books were at slightly different levels so that she could either work on a higher or lower level, depending on her feeling at the particular time. Coloring series of objects and drawing dot-to-dot with numbers helped her activity in this area. We also used coins in playing store for developing number concepts. In basic skills we worked in three books from the ABC Dictation Skills Program by William C. McMahon, published by Educators Publishing Service. She used both the numeral and alphabet book. Also she used My Alphabet Book, by Wilson and Rudolph and published by the Merrill Publishing Company. I hoped she would continue in a similar program in the classroom with increased use of visual sight words. She was a highly motivated, extremely hard-working child who, despite our three sessions a week, insisted upon taking work home with her and working first with her mother and then with her sister, as she felt in a better position to expose herself and compete with her.

After two years in a special school, Betsy's teachers felt she was ready for a small class in a private, non-competitive school. Testing was done a third time, showing good progress, but still considerable language difficulty. Our group and the

school director thought another year in special school would be useful, but Betsy and her teachers wanted change, and she went to a small local school where indeed she thrived for two years. Suggestions (by us) for supplemental language work were seen as unnecessary by the family. Therapy which these last two years was mainly for guidance and planning was discontinued.

In the middle of the fourth grade she came to my attention again. She was complaining of stomach aches, refusing to go to school, and again having temper tantrums at home. Several factors appeared to be at work but could only be gleaned from careful interview of all those concerned with Betsy's care. She still could not spontaneously verbalize her problems. Betsy's school work was excellent (showing only small traces of language difficulty), but when she was under stress because of family problems it deteriorated slightly. This brought criticism from the teacher and apparently inner despair for Betsy since her school achievements had become a source of considerable gratification. The situation deteriorated in circular fashion until the crisis brought her back to attention. Despite her difficulty in verbalizing, she soon responded to therapy and returned to school and high level academic work.

At just about this time her school was undergoing changes (although presumably she knew nothing of this). Her teachers recommended that she transfer to a different school for the

next year. We did further testing to assist in planning. By now Betsy was functioning above grade level. Yet the individual tests showed her still having difficulty spontaneously construing interrelationships (Comprehension, TAT stories). Of special interest was her inability to respond to the Rorschach cards. Under stress her vulnerability still showed.

In therapy sessions she could not talk easily yet was too "grown up" to allow herself to use play materials. We decided to bring her mother into some sessions to help her verbalize. At this point, family, child, and therapist have agreed to further work in facilitating spontaneous language expression.

Case Example II: Betsy

WISC SCORES

| AGE | 5.7 | 6.6 | 8.6 | 10.7 |
|---|---|---|---|---|
| Information | 6-7 | 8 | 8 | 10 |
| Comprehension | 8 | 5-7 | 6 | 6 |
| Arithmetic | 9 | 11 | 14 | 13-16 |
| Similarities | 10 | 12-18 | 14 | 14 |
| Vocabulary | 8-9 | 7-11 | 7 | 8-12 |
| Digit Span | 6-9 | 9 | 7 | 6-9 |
| Verbal I.Q. | 86-9 | 91-106 | 99 | 110-100 |
| Picture Completion | 14 | 13 | 9-11 | 10-11 |
| Picture Arrangement | 13 | 12 | 10 | 11 |
| Block Design | 10-12 | 11 | 12 | 13-15 |
| Object Assembly | 10 | 9 | 12 | 12 |
| Coding | 11 | 14 | 12 | 18 |
| Performance I.Q. | 114 | 113 | 106 | 114-124 |
| Full Scale I.Q. | 101-102 | 101-109 | 102 | 110-118 |

Case Example II: Betsy

ACHIEVEMENT SCORES

| | | |
|---|---|---|
| Age | 7.7<br>End "First Grade" | 8.6<br>End "Second" |
| Metropolitan | | |
| Word Knowledge | 1.9 | |
| Word Discrimination | 2.2 | |
| Reading | 2.0 | 2.9 |
| Arithmetic | 2.3 | 3.2 |
| Age | 10.2<br>Beginning "Fourth" | 10.8<br>End "Fourth" |
| Iowa | | |
| Vocabulary | 5.6 | 6.9 |
| Reading | 5.0 | 5.8 |
| Language | 6.5 | 6.8 |
| Math | 5.8 | 7.0 |
| Total | 5.7 | 6.0 |

## Summary

Although professionals are growing more and more skilled in diagnosing learning disabilities, there is no uniformly accepted method of treatment. Numerous panaceas are offered. The authors recognize the value of many of the new techniques developed in recent years. However, any given technique must always remain supplemental to the development of a constructive worker-child relationship and to a flexible, adaptive methodology on the part of the worker. It is the child, not the technique, who must stand at the focal center of the remedial method if that method is to be effective. The child must be seen in his entirety as a sentient being, struggling with the confusions generated by his handicap, struggling with painful feelings and reactions, often conflicted in his relationships to parents, siblings, teachers and peers, and damaged in his self-esteem.

In the authors' experience a large proportion of children who present with learning difficulty also suffer from significant emotional dysfunction and impaired personality development. The authors have developed a combined treatment program that attends to both the emotional and learning problems of these children. This approach combines psychotherapy and remediation as an integrated modality-part and parcel of one another. It combines therapist and educator in a single figure for "psychotherapeutic remediation."

It has demonstrated its effectiveness when applied to properly selected cases of combined learning and emotional dysfunction. The authors describe the basic principles and techniques that they use in the diagnosis and treatment of these children, illustrating them with in-depth, longitudinal studies of two long-term cases from their practice.

## References

1. Reading Disorders in the United States, Report of the Secretary's (HEW) National Advisory Committee on Dyslexia and Related Reading Disorders, Department of Health, Education, and Welfare, Washington, D. C., 1969.

2. Kass, W., Schacht, L.S., and Schacht, M., Learning Problems, Neurological Deficit and School Force-Out, Workshop Summary, Newsletter, American Orthopsychiatric Association, XIII: 2:33, 1969.

3. Kass, W., and Schacht, L.S., Remedial Psychotherapy for Learning Deficits, Workshop Summary, Newsletter, American Orthopsychiatric Association, XIV: 2: 43, 1970.

4. Kass, W., and Schacht, L. S., Variety of Learning Disabilities: Remedial and Psychotherapy Issues, Symposium: Through the Learning Disabilities Maze, Rutgers University, Symposium 1972, pp. 8-9, New Jersey Association for Children with Learning Disabilities, Saint Elizabeth College, Convent Station, N. J. 07961.